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FISCAL IMPACT STATEMENT

LS 6665

BILL NUMBER: HB 1591

NOTE PREPARED: Feb 17, 2013

BILL AMENDED: Feb 14, 2013

SUBJECT: Medicaid Matters

FIRST AUTHOR: Rep. Clere

FIRST SPONSOR:

BILL STATUS: CR Adopted - 1st House

FUNDS AFFECTED: X GENERAL
X DEDICATED
X FEDERAL

IMPACT: State & local

Summary of Legislation: This bill requires the Office of Medicaid Policy and Planning (OMPP) to apply to the United States Department of Health and Human Services (DHHS) for a State Plan amendment or a Medicaid waiver to do the following:

- (1) Require a Medicaid recipient who is eligible for Medicaid based on the individual's aged, blind, or disabled status to enroll in risk-based managed care;
- (2) Authorize implementation of a Medicaid program to provide services to individuals with an income of less than 133% of the federal income poverty level and specify components to be requested for the program; and
- (3) Require certain Medicaid recipients with an income of at least 150% of the federal income poverty level to make premium payments and require Medicaid recipients to participate in cost sharing.

Resource limitations: The bill defines populations that may be subject to Medicaid resource requirements. It eliminates resource requirements in determining Medicaid eligibility for specified populations.

Risk-Based Managed Care: The bill specifies policies that must be included in a contract entered into between OMPP and a managed care organization. The bill requires the office to report to the Health Finance Commission before October 1, 2013, concerning Indiana's use of risk-based managed care in Medicaid.

Study Committee: The bill establishes the Indiana Affordable Care Committee and sets forth the committee's duties concerning the implementation of a health insurance exchange (HIX) and the definition of "essential health benefits".

Advisory Committee: The bill also establishes the Indiana Health Benefit Exchange Advisory Committee for the purpose of advising the office on policy and program administration concerning a health insurance exchange in Indiana and the expansion of Medicaid eligibility.

Effective Date: Upon passage; July 1, 2013.

Summary of NET State Impact: The provisions of this bill requiring Medicaid State Plan amendments or waivers depend on the approval of the federal Centers for Medicare and Medicaid (CMS) services. The provisions concerning the conversion of the state to 1634 disability determination status are assumptions that were included in the Medicaid Forecast of December 2012.

Explanation of State Expenditures: *Medicaid Expansion under the Affordable Care Act (ACA):* The bill requires that before July 1, 2013, OMPP is to apply for a Medicaid State Plan amendment to implement a program for individuals between the ages of 19 and 64 who have an annual household income of 133% of the federal poverty level (FPL) or below. (Because of required income disregards, the effective income level is 138% FPL.) The bill specifies certain components that must be included in a State Plan amendment for the expansion. Should the U.S. DHHS approve the State Plan amendment, the estimated fiscal impact would be as discussed below.

Medicaid Expansion to 133% FPL. This analysis is based on the September 18, 2012, “ACA - Medicaid Financial Impact Analysis” prepared by Milliman, the state’s contracted Medicaid actuary. It is assumed that ACA-required expenses unrelated to any expansion of eligibility as projected by Milliman (Scenario 1) are included in the Medicaid forecasted expenditures for the purposes of the budget. It is further assumed that the cost of the full expansion will be the scenario using the Milliman projected participation rates (Scenario 3), since the analysis specifically states that it should not be expected that the full participation projected in Scenario 4 will occur. The incremental cost to the state of an expansion of Medicaid eligibility on January 1, 2014, to 133% of FPL was estimated by Milliman as shown below.

Expansion to 133% FPL	FY 2014	FY 2015	FY 2016	FY 2017
Incremental State Dollars	\$ 66.6 M	\$ 106.6 M	\$ 103.8 M	\$ 175.2 M
Incremental Federal Dollars	\$ 1,286.3 M	\$ 2,666.7 M	\$ 2,792.2 M	\$ 2,856.7 M
Total Incremental Expenditures	\$ 1,352.9 M	\$ 2,773.3 M	\$ 2,896.7 M	\$ 3,031.9 M

Medicaid is jointly funded by the state and federal governments. The effective state share of program expenditures is approximately 33% for most current services. Current Medicaid medical services are matched by the effective federal match rate (FMAP) in Indiana at approximately 67%. Administrative expenditures with certain exceptions are matched at the federal rate of 50%. Under provisions of the ACA, the enhanced FMAP for the newly eligible population will be:

- (1) 100% for CY 2014, 2015, and 2016;
- (2) 95% in CY 2017;
- (3) 94% in CY 2018;
- (4) 93% in CY 2019; and
- (5) 90% in CY 2020 and thereafter.

The Milliman enrollment analysis for FY 2015, projects the total Medicaid/CHIP population to be 1,205,000 with no expansion. Expansion to 133% FPL is estimated to provide coverage to an additional 427,000 individuals for a total enrollment of 1,632,000.

The longer a state waits to expand Medicaid eligibility to 133% FPL, the more expensive it will become to implement after CY 2016. The U.S. DHHS has specified that the ACA enhanced FMAP for expansion populations is only available in the circumstance of a full expansion; partially expanding the Medicaid-eligible population to a lower FPL income standard would qualify only for the state's normal FMAP percentage.

Department of Corrections (DOC) and Family and Social Services Administration (FSSA) Expenditures: The fiscal impact of a Medicaid expansion on DOC and FSSA medical expenditures would be expected to produce some level of savings. However, there are no data available at this time regarding the extent of acute inpatient care paid for residents of state facilities. The State Budget Agency currently administers an annual General Fund appropriation of \$25 M specifically for payment for medically necessary services provided outside the institutions. The extent to which these services include inpatient services would determine the potential level of savings available. Initial savings may be offset by administrative expenses necessary for OMPP to implement a program and coordinate with the affected agencies.

Risk-based Managed Care: The bill requires the OMPP to present a plan before October 1, 2013, to the Health Finance Commission concerning the mandatory use of risk-based managed care for populations currently being served under fee-for-service Medicaid. (Currently, this is mainly the aged, blind, and disabled population.) The bill specifies information and recommendations that must be included in the plan. The Health Finance Commission reporting requirement should be accomplished within the current levels of resources available to OMPP. The bill also specifies that before July 1, 2013, OMPP is to apply for a Medicaid waiver that would require an aged, blind, or disabled Medicaid recipient enroll in the risk-based managed care program. OMPP currently operates Care Select, a managed care program for individuals in the aged, blind, and disabled eligibility categories - it is not mandatory at this time. The bill further requires the implementation of the waiver not later than October 1, 2013, if it is approved by CMS. The fiscal impact of this provision is not known at this time.

Medicaid Cost-Sharing State Plan Amendments: The bill requires FSSA to apply for a State Plan amendment that would require Medicaid recipients to participate in cost sharing as allowable under federal law. Certain Medicaid recipients may already be subject to cost sharing since a limited amount of cost sharing is allowable under federal law. The ACA allows states to design alternate benefit packages within specified parameters for defined populations. Proposed federal rules have been drafted that allow for higher cost sharing for individuals with incomes above 100% of FPL. However, without a specific proposal, the fiscal impact of this provision is indeterminate. The bill also requires a State Plan amendment to require that Medicaid recipients with income of at least 150% of the FPL pay premiums to participate in the program. The cost of this provision would depend on the number of individuals meeting the income qualifications, the cost of services to be accessed, and the level of any premiums to be collected. The fiscal impact of this provision is not known at this time.

Resource Limitations: The bill specifies that the aged, blind, and disabled population will be subject to asset limitations established by the federal Supplemental Security Income program. It also specifies that certain resource standards may be applied to recipients and applicants who are aged, blind, disabled, SSI-eligible, a person meeting institutional level-of-care requirements and applying for long-term care services, or an individual applying for Medicare cost-sharing assistance. These provisions are linked to the conversion of the state to 1634 disability determination status that is included as an assumption used to develop the December Medicaid forecast.

Study Committee: The bill establishes the 14-member Affordable Care Study Committee consisting of 8 legislators, 3 lay members, and 3 state employees. The committee is to operate under the policies governing study committees adopted by the Legislative Council. Legislative Council resolutions in the past have established budgets for interim study committees in the amount of \$9,500 per interim for committees with fewer than 16 members. The Committee would be staffed by the Legislative Services Agency (LSA). The Committee is to study and make recommendations concerning the establishment of a HIX in Indiana, and the definition of Essential Health Benefits for use in the state. The committee is also to receive and consider annual reports from FSSA concerning the status and operation of the HIX established for Indiana.

Advisory Committee: The bill also establishes the 12-member Indiana Health Benefit Exchange Advisory Committee for the purpose of advising the OMPP on policy and program administration concerning a HIX in Indiana and the expansion of Medicaid eligibility. The bill specifies 9 laymembers who are to be appointed by the Governor and 3 ex officio members. The bill designates that an unspecified commissioner or a designee shall serve as the chairperson of the committee and that the laymembers are not eligible for per diem allowance or for travel expenses unless there is sufficient money available from federal grant funds or revenues generated by the exchange to provide for payment. The bill does not specify what agency would be responsible for staffing the advisory committee.

Additional Information-

Newly Eligible Expansion Population - Benchmark Benefits: Individuals who are included in the newly eligible group for Medicaid are entitled to benchmark benefits or benchmark-equivalent coverage rather than full Medicaid benefits. (Federal matching funds are not available for traditional Medicaid benefits for this group.) The minimum coverage requirements for benchmark-equivalent plans are inpatient and outpatient hospital services; physician and surgical services; laboratory and x-ray services, well-baby and well-child care, and other preventive services; prescription drugs; and mental health services.

Expansion Populations - DOC and FSSA: Currently, the Medicaid Act provides an exception to the inmate prohibition for federal matching funds when a resident or inmate becomes an inpatient in a medical institution. CMS has clarified that federal matching funds would be available when a resident or inmate is admitted as an inpatient to a hospital, nursing facility, juvenile psychiatric facility, or ICF-MR, provided that they meet any additional criteria for the services such as income eligibility or level-of-care requirements for long-term care. Current Indiana Medicaid eligibility is not available generally to nondisabled adults without dependent children. If Indiana Medicaid would be expanded under the Affordable Care Act to include adults under the age of 65 with income below 138% of the federal poverty level, this exception might provide for the possibility to realize increased savings on medical expenses incurred for residents of state-run institutions and inmates of correctional facilities. The inmate exception could also result in some savings with regard to inmates or residents that are currently eligible for Medicaid who require inpatient services; an example would be inpatient

labor and delivery services for pregnant women. The level of savings available would depend on the extent of services currently provided that could qualify for Medicaid federal financial participation and the expansion

Medicaid Expansion: The Milliman analysis excluded the college and graduate student population because the data indicated they may not have been appropriately grouped with their parents, causing an inappropriate match between income level and insurance coverage. The exclusion of this group may cause the expansion costs to move towards the maximum exposure cost range included in the analysis. Connecticut, a state that chose to expand the low-income population early, found that families have dropped insurance coverage for their college students when they determined they could be covered at no cost under Medicaid. Connecticut has requested a waiver from CMS that would allow students claimed as dependents for purposes of a parent's income tax liability be excluded from Medicaid coverage.

Risk-based Managed Care: The Medicaid managed care programs (Hoosier Healthwise and Select Care) operate under federally approved waivers. The regulation waived is the recipient's freedom of choice. Managed care organization's (MCO's) recipients select or are assigned a primary care provider to give the individual a "medical care home". The primary care provider is then responsible for that recipient's preventative and routine care. Controlling the cost of inappropriate use of services, such as emergency department services, is one of the methods that MCOs use to control costs within the network. The state pays a predetermined capitated amount for each MCO member per month regardless of the cost incurred by the MCO for the member's care.

Explanation of State Revenues: *Medicaid Expansion to 133% FPL.* [See *Explanation of State Expenditures* for the discussion of federal Medicaid matching funds.]

Explanation of Local Expenditures: *Medicaid Expansion to 133% FPL and Township Trustees:* Expansion of Medicaid to the low-income adult population could result in savings to townships and counties by virtue of providing Medicaid coverage for the adult population that would be newly eligible for coverage. In CY 2011, township trustees provided just over \$1 M in healthcare expenditures from township sources. There are no data to indicate whether expenditures were for services or products that would have been covered by Medicaid or if the individuals on behalf of whom expenditures were made would have been eligible for Medicaid under the required ACA expansion.

Explanation of Local Revenues:

State Agencies Affected: FSSA, OMPP; DoI; DOC; ISDH; LSA.

Local Agencies Affected: Township trustees.

Information Sources: "ACA - Medicaid Financial Impact Analysis", Milliman, September 18, 2012; "Township Assistance Report, 2011", DLGF Data Base; Wall Street Journal, July 1, 2012, "Connecticut Seeks to Tighten Medicaid Eligibility"; CCH's Law, Explanation and Analysis of the Patient Protection and Affordable Care Act, Including Reconciliation Act Impact, Volume 1, Wolters Kluwer, CCH, Aspen Publishers.

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